EXHIBIT 16

PLEASE DO NOT DETACH

United States Medical Licensing Examination™

UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE)
STEP 1 AND/OR STEP 2 EXAMINATIONS

ADMINISTERED TO STUDENTS/GRADUATES OF FOREIGN MEDICAL SCHOOLS BY
THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES, 3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, USA
PHONE: 215 386-5900 CABLE: EDCOUNCIL,PHA

PART A

NOTE: All items on all sides of the application must be filled out completely for initial and reexamination or application will not be accepted.
Use typewriter or block print in ink.

① ECFMG EXAMINATION HISTORY:
Have you ever submitted an application to ECFMG for any examination, even if you did not take the examination?
☐ Yes ☑ No
If yes, enter your USMLE Identification Number (ECFMG Applicant Number) in this box. 553-258-

② NAME: Print your name as you want it to appear on the Standard ECFMG Certificate and on your official USMLE record
First Name: JOHN
Middle Name: NOISAT
Last Name (Surname): AKODIA
Full Maiden Name (For married women only):

②.1 If you have previously applied to ECFMG under another name, provide that name
Previous Name:
Please include a copy of the legal document that verifies this name change.

③ ADDRESS: Use address to which admission permit and other notification from ECFMG should be sent
Number/Street: 4713 WEST BRADDOCK ROAD
Apartment Number: ELEVEN (11)
Post Office Box Number:
City: ALEXANDRIA
State/Country: VIRGINIA
Zip or Postal Code: 22311

JAN 3 1996

④ U.S. SOCIAL SECURITY AND/OR NATIONAL IDENTIFICATION NUMBERS:
Enter U.S. Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐
Enter National Identification Number and Country:
Country:

⑤ STATUS OF MEDICAL SCHOOL STUDENT: *Must* be completed by students.
If you are applying for Step 1, will you have completed two years of medical school by the date of that examination? ☐ Yes ☐ No
If you are applying for Step 2, will you have completed or be within 12 months of completion of the formal didactic curriculum at your medical school by the date of that examination? ☑ Yes ☐ No

⑥ REGISTRATION: Select no more than one box for each Step and/or ECFMG English test for which you are applying.

Step 1 (Check one box only)	Step 2 (Check one box only)	ECFMG English Test (Check one box only)
☑ June 11-12, 1996	☑ March 5-6, 1996	☑ March 6, 1996
or	or	or
☐ October 15-16, 1996	☐ August 27-28, 1996	☐ August 28, 1996

⑥.1 TEST CENTER: Select three different ECFMG centers in order of preference for each Step and/or ECFMG English Test. See the Information Booklet in which this application was enclosed for a list of ECFMG centers.

If your center selections are not available, ECFMG reserves the right to assign a center.

Step 1: (1) NEW YORK (330) (2) NEW YORK 330 (3) _____
City / Center No. / City / Center No. / City / Center No.

Step 2 and/or ECFMG English Test: (1) NEW YORK 330 (2) NEW YORK 330 (3) _____
City / Center No. / City / Center No. / City / Center No.

⑦ EXAMINATION FEE(S): Enter the amount enclosed on the line provided

Fees must be paid in United States funds. Checks, bank drafts or money orders are to be made payable to the ECFMG. Do not send cash.

Step 1 Basic Medical Science Examination	$440
Step 2 Clinical Science Examination	$440
ECFMG English Test	$ 40

Enter amount enclosed $ 480.00

480 | 00 | 40
FOR OFFICE USE ONLY

⑧ HANDEDNESS: ☐ Right Handed ☐ Left Handed

ECFMG-000703

ECFMG_RUSS_0000703

PART B

⑨ SECONDARY SCHOOL/ COLLEGE UNIVERSITY ATTENDED:

List any secondary school, college, or university attended.

Name / City/State/Country	Dates Attended From MO.	From YR.	To MO.	To YR.	No. School Years
UNIVERSITY OF BENIN	OCT	1981	OCT	87	6
BENIN CITY NIGERIA					

⑩ MEDICAL DEGREE AND ⑩.1 MEDICAL SCHOOL: 690-003

Title of Medical Degree: MBBS — Date Conferred/Expected:* MO. ____ YR. ____

* If the degree has been conferred, a photocopy must be sent to ECFMG. See *Medical Education Credentials* section of the ECFMG Information Booklet.

Name of Medical School from which you graduated or expect to graduate. LIST EXACT NAME AND ADDRESS.

Name / City/State/Country	Dates Attended From MO.	From YR.	To MO.	To YR.	No. of Years Attended
UNIVERSITY OF BENIN BENIN CITY NIGERIA	10-	81	10-	87	6

⑩.2 OTHER MEDICAL SCHOOLS ATTENDED:

Name / City/State/Country					

⑩.2 CLINICAL CLERKSHIPS:

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
	See Part D of this application for entering clinical clerkships.			

⑪ MEDICAL LICENSURE: Present or Future

Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine: MO. JAN YR. 1989

Country or state in which you are licensed:* ____

* If the license has been issued, a photocopy must be sent to ECFMG. See *Medical Education Credentials* section of the ECFMG Information Booklet.

⑫ HOSPITAL TRAINING: Residency or fellowship

Hospitals	Position(s)	Dates

⑬ EMPLOYMENT: Present employment only

Institution/Company	Position	Dates
Name: A. UNEMPLOYED		
Street:		
City/State/Country:		

⑭ BIRTHDATE/ BIRTHPLACE: Day 01 Month 01 Year 59 Location: BENIN CITY NIGERIA
City, Province, Country

⑮ GENDER: Please check one: ✓ Male ___ Female

⑯ NATIVE LANGUAGE: ____

⑰ CITIZENSHIP: (Complete all three)

A. AT BIRTH	USA ☐ or	Other ☐ (Specify)	NIGERIAN 056
B. UPON ENTERING MEDICAL SCHOOL	USA ☐ or	Other ☐ (Specify)	NIGERIAN
C. NOW	USA ☐ or	Other ☐ (Specify)	NIGERIAN ✓

⑱ OTHER EXAMINATION HISTORY AND APPLICANT NUMBERS:

Check below the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.

ORGANIZATION	DATE OF MOST RECENT EXAMINATION TAKEN	APPLICANT IDENTIFICATION NUMBER
☐ NATIONAL BOARD OF MEDICAL EXAMINERS	MO. ____ YR. 19	NBME Parts I/II
	MO. ____ YR. 19	USMLE Steps 1/2 ___-___-___-___
☐ STATE LICENSING AUTHORITY IN THE UNITED STATES	MO. ____ YR. 19	FLEX FEDERATION IDENTIFICATION NUMBER (FIN)

PART C

PART C

Students and graduates must sign the application in the presence of their Medical School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a **graduate** cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) *and* must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.

Seal, stamp or signature of official *must cover* a portion of the attached photograph.

(19) CERTIFICATION BY APPLICANT

I hereby certify that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition (that which pertains to the administration for which I am registering) of the combined Information Booklet on ECFMG Certification and Application for USMLE Step 1 and Step 2 examinations and USMLE Bulletin of Information, am aware of the contents of both sections and meet the eligibility requirements set therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See Information Booklet for additional details concerning Validity of Scores and Irregular Behavior.)

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

Signature of Applicant (In Latin Characters) X [signature] Date 12/31/95

RECEIVED JAN 3 1998 ECFMG

(19.1) CERTIFICATION BY MEDICAL SCHOOL OFFICIAL

OR

CERTIFICATION OF IDENTIFICATION WITH EXPLANATION (Pertains to graduates only)

A. I hereby certify that the photograph, signature, and information entered on Section 10 of this form accurately apply to the individual named above.

X _____
Signature of Medical School Official (In Latin Characters)

Official Title | Date | Institution

B. I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn to before me by the applicant on this 2 day of January, 1996 (NY)

X [signature] Notary Public 2
Signature of Consular Official, First Class Magistrate, Notary Public (In Latin Characters) Official Title

My Commission Expires on Sept 30, 1998: Stafford County Virginia

B.1 Explain in the space below why the application could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

Because the postal system to Nigeria could not be guarranteed within the available time

FOR OFFICE USE ONLY	
FORM	DATE
S.A.	
I.D.	2/8/96 (SD)
338	
339	
325	2/8/96 (SD)
P.	M 2/8/96 (SD)

(20) Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked? ☐ Yes ☒ No

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

(21) Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information; however, the processing of your application will not be affected if you choose to leave item (21) blank.

Select the one which best describes your racial/ethnic background.

1 ☐ American Indian/Alaskan Native
2 ☐ Asian Pacific Islander
3 ☐ Hispanic
4 ☒ Black (not of Hispanic Origin)
5 ☐ White (not of Hispanic Origin)
6 ☐ Other

PART D

(10.2) CLINICAL CLERKSHIPS: Refers to that period of medical education in the clinical disciplines during which as a medical student you gained practical experience in hospitals or clinics.

List clerkships (rotations, pre-graduate internships) for each clinical discipline.

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship
Pediatrics	General Hosp. Warri		Dr Asemota	11 87
Medicine	General Hosp Warri		NWOSU	0288
OBGY.	General Hosp Warri		Dr Iyinbor	0688
SURGERY	EKU Gen. Hosp. Warri		Dr Henderson	0988

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